EDMUND G. BROWN JR.
Attorney General of California
JAMES M. LEDAKIS
Supervising Deputy Attorney General
MARICHELLE S. TAHIMIC
Deputy Attorney General
State Bar No. 147392
110 West "A" Street, Suite 1100
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-3154
Facsimile: (619) 645-2061
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MARGARET KELLER THRIFT aka MARGARET KELLER MIDDLETON** 33101 Regatta Court San Juan Capistrano, CA 92675 **Registered Nurse License No. 380540** Respondent.	Case No. 2011- 111 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about December 31, 1984, the Board of Registered Nursing issued Registered Nurse License Number 380540 to Margaret Keller Thrift, aka Margaret Keller Middleton (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2012, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Section 2811(b) of the Code provides, in pertinent part, that the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY AND REGULATORY PROVISIONS

7. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions. . . .

8. California Code of Regulations (CCR), title 16, section 1442, states:

> As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

9. California Code of Regulations, title 16, section 1443, states:

> As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as

described in Section 1443.5.

10. California Code of Regulations, title 16, section 1443.5 states:

> A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:
>
> . . .
>
> (2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.
>
> . . .
>
> (4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.
>
> (5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.
>
> . . . .

COST RECOVERY

11. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTS

12. On July 1, 2009, South Coast Medical Center was acquired by Mission Hospital. Respondent was employed by South Coast Medical Center as a registered nurse and continued on with Mission Hospital after it acquired South Coast Medical Center. On August 13, 2009, Respondent was the Charge Nurse on duty of the Emergency Department at Mission Hospital – Laguna Beach. At 0008 hours on August 13, 2009, John S. was brought to Mission Hospital – Laguna Beach by a deputy from the Orange County Sheriff's Department. Mr. S. requested that

he be brought to Mission Hospital and "put on a 5150" because he feared for his own safety.[1] He also told his wife and a friend that was going to hurt himself. Mr. S. reported to the deputies that he had not eaten anything in three days and could not remember the last time he was sober. He was also extremely intoxicated.

13. Mr. S. was admitted to the Emergency Department of Mission Hospital and was diagnosed with depression with suicidal ideation and acute alcohol intoxication. Respondent was Mr. S.'s assigned nurse. Respondent completed the initial assessment of Mr. S. in which she charted that Mr. S. denied being suicidal. He was hypertensive with a blood pressure of 139/105. His speech was slurred. She determined that Mr. S. was under the influence of alcohol but was not a threat to his own safety. Respondent assigned Mr. S. a triage level of "3" according to the Emergency Severity Index ("1" is the most urgent and "5" is the least urgent).[2]

14. Respondent's nursing care plan was to complete Mr. S.'s laboratory work, feed Mr. S. and allow him to sleep. Since Mr. S. did not have the financial means to pay for his care at Mission Hospital, Respondent planned to have Mr. S. transferred to ETS, a county facility. However, Respondent knew that ETS would not accept Mr. S until his blood alcohol level was .150 or less. Mr. S.'s blood alcohol level was .393 at 0100 hours and Respondent knew that Mr. S. would be in the hospital all night before his blood alcohol level reached the acceptable level for transfer to ETS.

15. Respondent had Mr. S. undress and remove his jewelry. Mr. S. was placed in a gurney in front of the nurse's station. Mr. S. was given a snack and fell asleep on the gurney. Respondent's primary concern with Mr. S. was not that he would harm himself, but was

---

[1] Welfare and Institutions Code section 5150 states in pertinent part: "When any person, as a result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, member of the attending staff, as defined by regulation, of an evaluation facility designated by the county, designated members of a mobile crisis team provided by Section 5651.7, or other professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody and place him or her in a facility designated by the county and approved by the State Department of Mental Health as a facility for 72-hour treatment and evaluation...."

[2] "The Emergency Severity Index (ESI) is a five-level emergency department (ED) triage algorithm that provides clinically relevant stratification of patients into five groups from 1 (most urgent) to 5 (least urgent) on the basis of acuity and resource needs." Wikipedia, http://en.wikipedia.org/wiki/Emergency_Severity_Index.

"elopement". Therefore, when a room became available at 0120 hours, Mr. S. was awakened and accompanied to the room. The interior of the room could be observed from the nurse's station via video cameras. The door and a wall of the room had glass windows with blinds. Prior to leaving Mr. S. in the room, Respondent lifted the blinds over the glass in the door window and the wall. Respondent did not check the room for items that could be harmful to Mr. S.

16. Respondent and A.R., a patient care technician, observed Mr. S. via the video monitor. At 0230 hours, A.R. obtained a urine sample from Mr. S. and gave him some food. At 0308 hours, a patient was brought to the Emergency Department with a broken nose. Respondent and A.R. both attended to this patient. The two other nurses on duty in the department were on break. At 0320 hours when A.R. returned to the nurse's station, he noticed that Mr. S. was not lying on the gurney in his room. A.R. approached the room. A.R. could see Mr. S. lying on the floor between the gurney and the bathroom door. When A.R. entered the room, he saw Mr. S. lying on the floor with suction tubing wrapped around his neck. The tubing had been tied to the door hinge on the outside of the bathroom door. The autopsy report listed Mr. S.'s cause of death as ligature hanging; the manner of death was suicide.

17. During the time that Mr. S. was in the Emergency Department, Respondent did not complete the 24-Hour Suicide Assessment and Daily Record nor the patient observation check list.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Incompetence)

18. Respondent is subject to disciplinary action under section 2761(a)(1) for incompetence within the meaning of CCR 1443 and 1443.5 in that she lacked, or failed to exercise, that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as follows and as set forth above in paragraphs 11 through 16, which are incorporated herein as though set forth in full.

19. Respondent failed to formulate a care plan that ensured that direct and indirect nursing care services provided for the client's safety:

a. Respondent failed to perform a suicide risk assessment in light of Mr. S.'s comments to his friend and the officer that he wanted to be brought to the hospital for a "5150". The risk assessment is to determine how often the patient will need to be assessed by the registered nurse.

b. Respondent incorrectly assigned Mr. S. a level 3 triage, when he should have been given a level 2 triage. The Emergency Severity Index Triage Level states that any patient who presents with a "high risk" situation, such as an intent to commit suicide, be placed as a level 2 triage.

c. Respondent failed to check the room in which Mr. S. was placed for potentially harmful items.

c. Respondent failed to obtain a repeat blood pressure when Mr. S. presented to the Emergency Department with an elevated blood pressure.

20. Respondent failed to delegate tasks to subordinates and effectively supervise nursing care given by subordinates in that Respondent was in charge of the Emergency Department:

a. Respondent assumed charge of the Emergency Department without being aware of the proper procedure for treatment of a behavioral patient in the Emergency Department.

b. Respondent did not assign staff to observe Mr. S.

c. Respondent did not properly supervise staff to check Mr. S' vital signs.

d. At the time of Mr. S.'s suicide, Respondent and A.R. were the only staff present with three patients in the Emergency Department.

21. Respondent failed to evaluate the effectiveness of the care plan through observation of the client's physical condition and behavior in that Respondent:

a. failed to perform a suicide risk assessment;

b. failed to obtain repeat vitals.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Gross Negligence)

22. Respondent is subject to disciplinary action under section 2761(a)(1) for gross negligence within the meaning of CCR 1442 in that she failed to provide care or exercise ordinary

precaution in a single situation that she knew, or should have known, could have and did in fact jeopardize a patient's health or life as set forth above in paragraphs 11 through 20, which are incorporated herein as though set forth in full.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 380540, issued to Margaret Keller Thrift;

2. Ordering Margaret Keller Thrift to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 8/9/10

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SD2010701348
70321326.doc